

If the hospital does not have a unit which is a nursing facility, the per diem paid for days awaiting placement will be the statewide average skilled care rate being paid nursing facilities by the Wisconsin Medicaid program.

If the hospital has a unit which is a nursing facility, the rate paid for days awaiting placement will be the rate per diem paid for skilled care in the hospital's nursing facility at that time.

Days awaiting placement may not qualify for payment if the hospital has a unit that is a nursing facility and either of these conditions exist.

- (a) The nursing facility unit of the hospital is holding a bed for the hospitalized patient. This includes anytime the nursing facility is being paid for holding a bed for the patient or anytime the nursing facility is required to hold a bed for the patient even if payment is not provided for holding the bed.
- (b) The hospital had an excess number of unutilized beds during the final settlement year in which there were patient days awaiting placement. The Department deems that a daily average of eight or fewer unutilized beds during the final settlement year means that the hospital did not have an excess number of unutilized beds.

6256 Final Settlement

The hospital will be reimbursed its cost of hospital services provided Medicaid recipients. Such reimbursement will be limited by the maximum described in section 6253. Capital related costs and direct medical education costs will be reimbursed without limitation by the maximum. The cost incurred will be determined from the hospital's audited Medicaid cost report for its fiscal year.

Hospital service days. For the final settlement calculation, a hospital service day is a day during which a patient requires hospital care and not a day awaiting placement described in section 6255. For determining the cost per diem for hospital service days, any day on which a person is residing in the hospital, including days awaiting placement, will be counted as a day.

Gross maximum reimbursement. Total or gross maximum reimbursement will be calculated by multiplying the maximum per diem of section 6253 by the total Medicaid hospital service days provided by the hospital during its fiscal year. Capital related cost and direct medical education cost for Medicaid hospital service days will be added to the gross maximum amount. For determining this cost, total capital and total direct medical education cost will be divided by total patient days of the hospital. Then the resulting per diem cost will be multiplied by the Medicaid hospital service days of the hospital resulting in the total Medicaid capital and direct medical education cost.

Gross cost of Medicaid hospital service days. The total or gross cost for hospital service days of Medicaid recipients will be determined by: (1) dividing the total cost of the hospital services from the audited cost report, including capital related costs and direct medical education costs, by total patient days of the hospital, (2) multiplying the resulting cost per diem by the total Medicaid hospital service days and the reimbursable Medicaid days awaiting placement, and (3) from the resulting cost, subtract the reimbursement for Medicaid days awaiting placement. The result is the gross cost for Medicaid hospital service days.

Final total reimbursement. The lesser of the above gross maximum or the gross Medicaid cost is the allowed reimbursement for hospital service days of Medicaid recipients. This lesser amount plus the reimbursement for Medicaid days awaiting placement (§6255) plus a disproportionate share adjustment if the hospital qualifies will be final total reimbursement subject to limitation by charges according to section 6257. To determine the disproportionate share adjustment, the allowed reimbursement for Medicaid hospital service days will be multiplied by any disproportionate share adjustment percentage for which the hospital may qualify under section 5240, not to exceed 5.5%.

If the final total reimbursement exceeds the total interim payments, then the difference will be paid to the facility. The difference will be recovered if the final total reimbursement is less than the total interim payments. Final settlement reimbursement will be determined as shown in the example in the following section 6259.

6257 Payments Not to Exceed Charges

According to section 9000, the final combined reimbursement for hospital service days and days awaiting placement may not exceed the combined charges for the Medicaid hospital service days and the Medicaid days awaiting placement.

6258 Approval of Discretionary Waiver or Variance for Professional Services

As provided under the Wisconsin Administrative Code, HSS 106.13, the Department may grant a discretionary waiver or variance to include the cost of professional services in the final settlement only if it finds all of the following are met:

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Page 26.1.b

(New Page 1/1/96, TN 98-001)

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Page 26.1.b

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Substitute Page

- "(a) The waiver or variance will not adversely affect the health, safety or welfare of any recipient;
 (b) Either; 1. Strict enforcement of a requirement would result in unreasonable hardship on the provider or on a recipient; or 2. An alternative to a rule, including a new concept, method, procedure or technique, new equipment, new personnel qualifications or the implementation of a pilot project is in the interests of better care or management;
 (c) The waiver or variance is consistent with all applicable state and federal statutes and federal regulations;
 (d) Consistent with MA State Plan and with federal Health Care Financing Administration and other applicable federal program requirements, federal financial participation requirements, federal financial participation is available for all services under the waiver or variance; and
 (e) Services relating to the waiver or variance are medically necessary."
 (Quoted from Wis. Admin. Code, HSS 106.13.)

6259 The Example of a Final Settlement Calculation

For a settlement year, total costs of \$575,125 were apportioned to the hospital in the hospital's audited cost report. The hospital had a total of 1,075 patient days in the following categories: 720 Medicaid hospital service days, 75 reimbursable Medicaid patient days awaiting placement, 20 nonreimbursable Medicaid patient days awaiting placement and 280 days for non-Medicaid patients.

Maximum for Medicaid Hospital Service Days

Maximum Rate Per Diem determined under 50253	\$ 579
Times: The inflation multiplier to inflate to settlement year	<u>1.0262</u>
Maximum per diem on hospital service days	\$ 600
Times: Total Medicaid hospital service days	<u>720</u>
Maximum not including capital and direct medical education costs	\$ 432,000
Total capital & direct medical education costs	\$ 22,575
Divide by: Total days	1,075
Times: Medicaid hospital service days	<u>720</u>
Add: Capital & direct medical education costs for Medicaid hospital service days	\$ 15,120
Maximum reimbursement for Medicaid hospital service days including capital costs and direct medical education costs	<u>\$ 447,120</u>

Calculation of Medicaid Cost for Hospital Services

Total hospital cost from the cost report	\$575,125
Divide by: Total days	<u>1,075</u>
Cost per diem	\$ 535
Times: Total reimbursable Medicaid days (Hospital 720 + Awaiting Placement 75)	<u>795</u>
Total Medicaid Cost	\$425,325
Offset to Cost by Amount of Reimbursement on Days Awaiting Placement:	
Skilled care rate to pay on days awaiting placement	\$135
Times: Total Medicaid days awaiting placement	<u>75</u>
Subtract: Reimbursement for days awaiting placement	<u>(\$ 10,125)</u>
Cost of Medicaid hospital service days including capital costs and direct medical education costs	<u>\$ 415,200</u>

Calculation of Final Reimbursement Amount

Maximum reimbursement for Medicaid hospital service days including capital costs and direct medical education costs	\$ 447,120
Cost of Medicaid hospital service days including capital costs and direct medical education costs	<u>\$ 415,200</u>
Reimbursement for hospital service days, lesser of maximum or cost	\$415,200
Times: Disproportionate share adjustment percentage	<u>5.43 %</u>
Add: Disproportionate share adjustment amount	\$ 22,545
Reimbursement for hospital service days with disproportionate share	<u>\$437,745</u>
Reimbursement for days awaiting placement:	
Skilled care rate to pay on days awaiting placement	\$ 135
Times: Covered Medicaid days awaiting placement	<u>75</u>
Add: Reimbursement for days awaiting placement	<u>10,125</u>
Total Available Reimbursement	\$447,870
Total charges (Payments are limited by charges per \$9000)	\$429,475
Add: Disproportionate share adjustment amount to charges	<u>\$ 22,545</u>
Total for charge limitation	<u>\$452,020</u>
Total Allowed Reimbursement, lesser of available reimbursement or charges	\$447,870
Subtract: Interim payments	<u>(\$398,500)</u>
Payment Due Provider for Final Settlement	<u>\$49,370</u>

Substitute page

6300 CALCULATION METHODOLOGY FOR REHABILITATION HOSPITALS

Section 6310 applies to established rehabilitation hospitals which are not considered new. Section 6320 applies to new rehabilitation hospitals for the period described in that section.

6310 Calculation of Per Diem Rates for Established Rehabilitation Hospitals

The following is the methodology to be followed for calculating a per diem payment rate for rehabilitation hospitals which are not new rehabilitation hospitals.

- 1) The Medicaid allowable costs from the audited cost reports for the hospitals' three base cost reporting years shall be indexed to June 30th of the earliest year of the three years by the DRI/McGraw Hill, Inc. HCFA Hospital Market Basket inflation rate. The "three base cost reporting years" for a hospital shall be the hospital's fiscal years which ended in the second, third and fourth calendar years preceding the calendar year of each annual rate update (defined §3000). (For example, for a July 1, 1992 annual rate update, the three base cost reporting years are a hospital's fiscal years which ended in 1990, 1989 and 1988 with costs being indexed to June 30, 1988, the earliest year of the three base years.) If needed audited cost reports are not available prior to a new rate year in order to calculate the annual rate update, then an interim rate shall be established for the new rate year until the audited cost reports are available.
- 2) Divide the total direct medical education costs for the three years by the total hospital costs for the three years to get the average percentage of direct medical education costs.
- 3) Divide the total capital related costs for the three years by the total hospital costs for the three years to get the average percentage of capital costs.
- 4) Multiply the total Medicaid allowable costs (step 1) by the percentage of direct medical education costs (step 2) to arrive at Medicaid direct education costs. (Steps 5 through 11 continued on next page)

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- 5) Multiply the total Medicaid allowable costs (step 1) by the percentage of capital costs (step 3) to arrive at Medicaid capital costs.
- 6) Subtract the Medicaid education costs (step 4) and the Medicaid capital cost (step 5) from the total Medicaid costs (step 1).
- 7) Multiply the Medicaid capital costs (step 5) by .95.
- 8) Add the Medicaid costs (step 6), the Medicaid direct medical education costs (step 4) and the reduced capital cost (step 7). This is the total adjusted Medicaid costs.
- 11) Divide the adjusted Medicaid costs (step 8) by the total Medicaid days from the three audited cost reports to get an adjusted Medicaid cost per diem.
- 11) Index the adjusted Medicaid cost per diem by the legislatively authorized increases through the current rate year and increase the per diem by the disproportionate share adjustment factor if applicable. The disproportionate share adjustment factor will be determined pursuant to section 5240.

6320 Rates for New Rehabilitation Hospitals

The Department will establish payment rates for new rehabilitation hospitals under a method other than that described above until cost reports are available for application of the above methodology.

6322 New Rehabilitation Hospital and Start-Up Period

The start-up period for a new rehabilitation hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends the June 30th date following completion of the hospital's fourth full (12 month) fiscal year after the fiscal year in which the first WMAP recipient was admitted. (For example, a hospital's fiscal year ends each September. It admitted its first WMAP recipient on March 10, 1994. Its fourth full fiscal year after the admission ends September 30, 1998. The next rate year begins July 1, 1999. Therefore, the hospital's start-up period is March 10, 1994 through June 30, 1999.)

6324 Rates for Start-Up Period

The rates per diem to be paid during the start-up period shall be an average of the rates being paid to other rehabilitation hospitals in the state, not including rates being paid new rehabilitation hospitals during a start-up period. If a rate being paid to a rehabilitation hospital is adjusted as is called for in step 1 of §6310, the statewide average rate will be recalculated. The start-up rate being paid to a new rehabilitation hospital will be adjusted prospectively based on the recalculated statewide average rate without a retroactive payment adjustment.

In calculating the statewide average rate, any disproportionate share adjustments which are provided to the other rehabilitation hospitals will not be included. The new hospital may request an 'administrative adjustment action' for disproportionate share adjustments to be applied to its start-up rates. Section 6328 below describes the criteria for the administrative adjustment action.

6326 Rates After Start-Up Period Ends

Rates will be established according to the methodology described in §6310 above after the start-up period ends. Two base cost reporting periods, not three as called for in step 1 of §6310, will be used for establishing rates for the initial rate year after the start-up period. (A rate year is July 1 to June 30.) For the subsequent rate years, three base cost reporting periods will be used as is specified in §6310.

6328 Administrative Adjustment Criteria for Disproportionate Share Adjustment for New Hospital

A new rehabilitation hospital may request a disproportionate share (DSH) adjustment under administrative adjustment item R in section 11900. For its rates during the start-up period and the first rate year after the start-up period, this administrative adjustment allows DSH adjustments to be based on Medicaid inpatient day utilization for periods other than that specified in §5243.

6400 OTHER PROVISIONS RELATING TO PER DIEM RATE SYSTEM -----**6410 Medically Unnecessary Days, Defined (Under Per Diem Rate System)**

Medically unnecessary days are those days that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See WIPRO review section below regarding criteria.)

6413 Authority For Recovery (Under Per Diem Rate System)

The Department will recover payments previously made or deny payments for medically unnecessary hospital stays or days and/or inappropriate services based on determinations by the Department, the Wisconsin Peer Review Organization (WIPRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMAP recipients and payments made to providers of such services. Wisconsin statute, section 49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

6414 Calculation Of Recoupment (Under Per Diem Rate System)

The amount to be recouped for medically unnecessary stays or days is calculated by multiplying the rate per diem times the number of denied days, less any co-payment or third-party payment

6416 Review by Wisconsin Professional Review Organization (WIPRO). Section 5816 applies to hospitals under the per diem rate system.

6419 WIPRO Control Numbers. Section 5819 applies to hospitals under the per diem rate system.

6423 Inappropriate Inpatient Admission. Section 5823 applies to hospitals having per diem rates.

6436 Days Awaiting Placement (Under Per Diem Rate System)

Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. Payment under the prospective rate-per-diem will be adjusted for days a WMAP recipient patient is awaiting placement to an alternative living arrangement. For those days identified as awaiting placement, payment shall be adjusted to an amount not to exceed the statewide average skilled care per diem rate for nursing facilities (NFs). Each allowed day awaiting placement shall be documented through patient chart review and subject to criteria established by the WMAP. The amount to be recouped is calculated by subtracting the skilled care rate from the rate per diem and multiplying by the days awaiting placement. The amount to be recouped is also reduced by the applicable amount of co-pay and third-party liability (TPL) payments.

6443 Temporary Hospital Transfers (Under Per Diem Rate System)

When an inpatient in a hospital paid under the prospective rate per diem system is transferred to an acute care general hospital and transferred back, no per diem payment shall be provided to the hospital for the days of absence. The acute care hospital, to which the patient temporarily transferred, will be reimbursed by the WMAP for the medically necessary stay.

6446 Outpatient Services Related to Inpatient Stay. Section 5846 applies to hospitals under the per diem rate system.

6453 Changes of Ownership. Section 5853 applies to hospitals under the per diem rate system.

6456 HMO/PEI Alternative Payment. Section 5856 applies to hospitals under the per diem rate system.

6460 Cost Report Used For for Recent Hospital Combinings (Under Per Diem Rate System)

Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. Data from the audited cost reports of each previous individual hospital will be combined to calculate any per diem rate which requires the use of audited cost reports. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used in the subsequent July 1 annual rate update. Under section 11900, item S, the combined or absorbing hospital may request the administrative adjustment to have its payments retroactively adjusted based on its audited cost report when they become available.

6470 SERVICES COVERED BY PER DIEM RATE PAYMENTS UNDER SECTION 6000

All covered services provided during an inpatient stay, except professional services described in §6480, shall be considered hospital inpatient services for which per diem payment is provided under this section 6000. (Reference: Wis. Admin. Code, HSS 107.08(3) and (4))

6480 PROFESSIONAL SERVICES EXCLUDED FROM PER DIEM RATE PAYMENTS UNDER SECTION 6000

Certain professional and other services are not covered by the per diem payment rates under this section 6000. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the per diem payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

- physicians
- psychiatrists
- psychologists
- physician assistants
- nurse midwives
- chiropractors
- dentists
- optometrists
- hearing aid dealers
- audiologists
- podiatrists
- independent nurse practitioners
- anesthesia assistants
- certified R.N. anesthetists

Any of the following provided on the date of discharge for home use:

- pharmacy, take home drugs
- durable medical equipment and supplies for non-hospital use
- specialized medical vehicle transportation
- air, water and land ambulances

SECTION 7000
SERVICES EXEMPTED FROM THE DRG PAYMENT SYSTEM

7100 PAYMENT FOR ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

7110 AIDS Acute Care and AIDS Extended Care Rates of Payment. (Rates listed in §7900)

The current payment rates per diem for AIDS acute care and for AIDS extended care are listed in section 7900. These per diem rates apply for instate hospitals, major and minor border-status hospitals and non-border status hospitals.

Total payment is calculated as the sum of the acute care per diem times the number of approved acute care days plus the extended care per diem times the number of approved extended care days. Payment will not exceed total covered charges.

7150 Patient Criteria For Approval To Receive AIDS Rate of Payment

7150.2 Acute Care. Payment of the acute care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria apply:

- a. The patient must have an established diagnosis of AIDS.
- b. Clinical findings and other relevant medical information must substantiate the medical necessity and appropriateness of the hospitalization and its payment at the AIDS acute care rate.
- c. Medical record documentation supporting the medical necessity and appropriateness of acute inpatient care must be submitted with the request for approval.

Approval for the acute care per diem is granted for a specified period of time. If the patient still meets the intensity and severity criteria for acute care, the provider must submit a subsequent request for extension of the payment approval..

7150.3 Extended Care. Payment of the extended care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria must be met:

- a. The patient must have an established diagnosis of AIDS.
- b. The patient must be medically stable per discharge indicators appropriate for the system involved.
- c. The patient must require infection control procedures and isolation techniques.
- d. Reasonable attempts at securing alternative living situations that allow for correct infection control procedures and isolation techniques must have been unsuccessful and an appropriate plan of care and discharge plan must have been established.
- e. The degree of debilitation and amount of care required must equal or exceed the level of skilled nursing care provided in a nursing facility (NF).
- f. Sufficient documentation supporting these criteria must be submitted with the request for approval.

Approval for the extended care rate is granted for a specified period of time, after which if the patient still meets the intensity and severity criteria for extended care, the provider must submit a subsequent request for extension of the payment approval.

The progression of illness may require acute care services during the period established for extended care. Therefore, during an "extended care" period, the acute care payment rate will be approved for payment after the hospital has provided an acute level of care for at least five days and the WMAP determines the above acute care criteria are met.

7160 No Outlier Payment and Administrative Adjustment.

AIDS cases paid under the per diem rate of this section do not qualify for outlier payments. AIDS reimbursement rates are not subject to administrative adjustment.

7170 If AIDS Exemption Discontinued

In the event that the AIDS payment rate is discontinued, the Department is obligated to pay for services at the latest rate adjusted annually for inflation until alternative placement for these patients can be found. The hospital will provide care to these patients at this latest rate until such time that an alternative placement can be found.

7200 PAYMENT FOR VENTILATOR-ASSISTED PATIENTS**7210 Rate of Payment** (Rates listed in §7900)

The *per diem* payment rate for long-term ventilator services is listed in section 7900. Hospitals are required to bill on a monthly basis. This rate applies to instate hospitals, major and minor border-status hospitals and non-border status hospitals.

7250 Criteria For Approval To Receive Ventilator-Assistance Payment Rate

7250.2 Patient Criteria. Payment of the ventilator-assistance rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP based on the following criteria. The request is to be submitted through the WMAP prior authorization (PA) process. If one or more of the following criteria are not met, payment of the ventilator-assistance rate may be approved by the WMAP if it is determined that payment of such rate to the hospital for the patient's stay is expected to be less costly than alternative ventilator assistance services.

- a. The patient must have been hospitalized continuously in one or more hospitals for at least thirty consecutive days;
- b. The ventilator-assisted patient must be in a medically stable condition requiring an inpatient level of care;
- c. Attempts at weaning the patient from the ventilator are inappropriate or must have failed;
- d. The ventilator-assisted patient must require ventilator assistance six or more hours per day;
- e. Home care must be an unacceptable alternative because of financial/economic hardship or because of the lack of adequate support system; and
- f. Nursing home placement must be inappropriate because of the high level or type of care required or non-availability.

7250.3 Dedicated Unit Provisions. If a hospital has a specialized nursing unit dedicated to the care of ventilator-assisted patients, the Department will allow the hospital to be reimbursed retroactive to the first day of the stay in the dedicated unit even if that date is prior to the date of approval for payment at the ventilator-assistance rate.

7250.4 Transfers. Hospitals will continue to be paid the ventilator rate when ventilator-assisted patients are transferred to acute care or intensive care units for complications associated with their ventilator dependency. Hospitals will be paid the prospective DRG rate for transfers and/or admissions to acute care settings for medical problems unrelated to their ventilator dependency, provided the acute care stay lasts more than five days.

7260 No Outlier Payment and Administrative Adjustment.

Claims for patients who are eligible for this exceptional payment rate cannot be reimbursed as outliers. The ventilator-assistance reimbursement rates is not subject to administrative adjustment.

7270 Ventilator-Assistance Exemption Discontinued.

In the event that the Department discontinues the ventilator-assisted payment rate, the Department is obligated to pay for services at the most current rate adjusted annually for inflation until such time as an alternate placement for patients is found. The hospital will continue to provide care to these patients at this rate until alternative placement is found.

7400 NEGOTIATED PAYMENTS FOR UNUSUAL CASES

Notwithstanding other reimbursement provisions of this plan, the Department may allow an alternative payment for non-experimental inpatient hospital services if the WMAP determines that all of the following requirements are met:

1. The services are either:
 - a. Necessary to prevent death of a recipient or
 - b. Life threatening impairment of the health of a recipient or
 - c. Grave and long lasting physical health impairment of a recipient or
 - b. Cost effective compared to an alternative service or alternative services.
2. At the time this plan was submitted, the service(s) as proposed:
 - a. Was not reasonably accessible for WMAP recipients; or
 - b. Had not been a WMAP approved service provided for the particular purpose(s) intended; or
 - c. Had not been a WMAP approved service provided under similar medical circumstances; or
 - d. Required performance in the hospital which, given the circumstances of the recipient's case, is the only feasible provider or one of the only feasible providers known to the WMAP.
3. Existing payment methods are inadequate to ensure access to the services proposed for the recipient.
4. All applicable prior authorization requirements are met.

This §7400 applies to in-state hospitals, major and minor border status hospitals, and out-of-state hospitals not having border status.

Alternative payments made under this provision shall be set on a case by case basis and shall not exceed the hospital's charges.

Requests for alternative payments under this provision are to be made to the: Office of the Director, Bureau of Health Care Financing, 1 West Wilson Street, Suite 250, P.O. Box 309, Madison WI 53701-0309 (telephone 608-266-2522 or FAX 608-266-1096).

Requests must be submitted prior to admission, during the hospital stay or not later than 180 days after the WMAP recipient's discharge from the requesting hospital in order for an alternative payment to apply, at the discretion of the WMAP, beginning with the admission date (if applicable prior authorization requirements have been met to allow retroactive payment).

7500 BRAIN INJURY CARE

7520 In-State and Border-Status Hospitals. A rate per diem is provided for prior authorized care of MA recipients in a hospital's brain injury care program which has been approved by the WMAP. The hospital's brain injury care program must be approved by the WMAP and each recipient's participation in the program must be prior authorized by the WMAP. The criteria for approval of a program and for prior authorization of an MA recipient's participation in the program is available from the Bureau of Health Care Financing (see address, section 100, page 1).

Periodic payment will be made to the hospital at the applicable rate per diem specified below. After completion of the hospital's fiscal year, total payments at the rates per diem in effect for brain injury care of prior authorized MA recipient services during its fiscal year will be determined. These total payments will be compared to the hospital's charges for the services and to the hospital's audited cost of providing the services. If the total payments exceed the total charges or the total costs, whichever is lesser, then the excess amount of payments will be recovered from the hospital.

The rates per diem for brain injury care programs for in-state and major and minor border status-hospitals are listed in section 7900. The WMAP may determine and approve additional rates for brain-injury care programs which provide significantly different services than are provided in the types of programs listed in section 7900.

7540 Non-Border Status Hospitals.

Out-of-state non-border status hospitals will be paid at 68% of charges for prior authorized stays for brain injury care.

7900 PAYMENT RATES FOR SERVICES EXEMPTED FROM DRG PAYMENT SYSTEM

These payment rates are established by applying the general payment rate increase provided by the state's biennial budget to the rate in effect for the prior rate year.

SECTION 7910. rates per diem

For Section	Services	Rate Per Diem		
		Effective July 1, 1996	Effective July 1, 1997	Effective July 1, 1998
7100	AIDS Acute Care.....	\$ 570	\$ 582	\$ 597
7100	AIDS Extended Care.....	\$ 314	\$ 321	\$ 329
7200	Long-Term Ventilator Services	\$ 444	\$ 453	\$ 465
7500	Brain Injury Care			
	Neurobehavioral Program Care	\$ 780	\$ 796	\$ 816
	Coma-Recovery Program Care	\$ 937	\$ 957	\$ 981

Note: Organ transplants for heart, liver, pancreas, bone marrow, lung and heart-lung are reimbursed under the DRG based payment method as of July 1, 1995. These organ transplants had been paid a fixed amount per case prior to July 1, 1995.

7990 SERVICES COVERED BY PAYMENT RATES IN SECTION 7900 ABOVE

All covered services provided during an inpatient stay, except professional services described in §7992, are considered hospital inpatient services for which payment is provided under the payment rates listed in section 7910 above. (Reference: Wis. Admin. Code, HSS 107.08(3) and (4))

7992 PROFESSIONAL SERVICES EXCLUDED FROM PAYMENT RATES IN SECTION 7910 ABOVE

Certain professional and other services are not covered by the payment rates listed in section 7910 above. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the above payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

- | | | |
|---|--|--|
| <input type="checkbox"/> physicians | <input type="checkbox"/> optometrists | <i>Any of the following provided on the date of discharge:</i> |
| <input type="checkbox"/> psychiatrists | <input type="checkbox"/> hearing aid dealers | |
| <input type="checkbox"/> psychologists | <input type="checkbox"/> audiologists | <input type="checkbox"/> pharmacy, take home drugs |
| <input type="checkbox"/> physician assistants | <input type="checkbox"/> podiatrists | <input type="checkbox"/> durable medical equipment and supplies for non-hospital use |
| <input type="checkbox"/> nurse midwives | <input type="checkbox"/> independent nurse practitioners | <input type="checkbox"/> specialized medical vehicle transportation |
| <input type="checkbox"/> chiropractors | <input type="checkbox"/> anesthesia assistants | <input type="checkbox"/> air, water and land ambulances |
| <input type="checkbox"/> dentists | <input type="checkbox"/> certified R.N. anesthetists | |